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Malnutrition

As the editor in chief, I welcome you to the second issue of Kompass Nutrition & Dietetics. I hope you enjoyed the first one!

On behalf of EFAD, I would like to thank Liana Poulia who was the editor of the first issue and also largely involved in the preparation of this second issue. Thank you, Liana, for your contributions to make the launch of Kompass Nutrition & Dietetics possible!

For future editions, we will work with an expert board to decide on upcoming topics. More information about the process and submitting procedures can be found on the EFAD website (www.efad.org/en-us/kompass-nutrition-dietetics/information-guidelines).

The topic of the current issue is malnutrition, which is a major problem around the world. Up until 2018, there was no consensus on the definition of malnutrition. In 2018, a consensus report from the global nutrition community was published. The Global Leadership Initiative on Malnutrition (GLIM) developed a consensus scheme for diagnosing protein-energy malnutrition in adults in clinical settings on a global scale [1]. According to GLIM criteria, diagnosing malnutrition starts with screening the patient using a validated screening tool. This is followed by a diagnostic assessment which provides information on phenotypic (non-volitional weight loss, low body mass index, reduced muscle mass) and etiologic (re-

duced food intake or assimilation, disease burden/inflammation) characteristics. If at least one phenotypic and etiological characteristic is present, the criteria for malnutrition are met. The severity of malnutrition can then be determined based on phenotypic criteria.

Several nutrition screening tools exist for both patients in various healthcare settings and community-dwelling patients. A good screening system is important for the early detection and treatment of malnutrition. In addition, prevention of malnutrition may be even more important. Besides knowledge and expertise from (healthcare) professionals, prevention requires awareness about malnutrition, i.e. the multiple risk factors for onset of malnutrition, among (healthcare) professionals, informal caregivers, and citizens.

Ultimately, malnutrition is caused by low food intake, reduced nutrient availability, or increased nutrient requirements; however, the reasons for these underlying causes are diverse: Inflammatory diseases may increase nutrient requirements; mobility limitations may cause difficulties with grocery shopping or meal preparation leading to decreased food intake; oral pain or chewing problems may hinder food intake; cognitive impairment, loss of interest in life, and many other conditions may further contribute to the development of malnutrition.

The DOMAP model clearly indicates all po-

tential determinants of malnutrition [2]. To prevent or treat malnutrition, it is necessary to detect why someone is – or may become – malnourished and thus establish a suitable treatment plan. After all, simply telling a person to eat more when, for example, the reason for the decreased food intake is oral pain, will not result in successful treatment. It requires collaboration between healthcare professionals, social workers, informal caregivers, and patients/citizens to prevent, screen for, diagnose, and treat malnutrition. This issue features knowledge transfer articles written by experts from various EFAD European Specialist Dietetic Networks which aim to bridge the gap between science and clinical practice.

Enjoy reading!

References

- 1 Jensen GL, Cederholm T, Correia MIT, et al.: GLIM criteria for the diagnosis of malnutrition: a consensus report from the global clinical nutrition community. *Journal of Parenteral and Enteral Nutrition* 2019;43:32–40.
- 2 Volkert D, Kiesswetter E, Cederholm T, et al.: Development of a model on determinants of malnutrition in aged persons: a MaNuEL Project. *Gerontol Geriatr Med* 2019;5: 2333721419858438.